DELTA DENTAL
Delta Dental Plan of Virginia

4818 Starkey Road, SW
Roanoke, Virginia 24014
Fax: (540) 776-8109

ENROLLMENT/CHANGE FORM

☐ New Enrollment ☐ Status Change* ☐ Cobra ☐ Contract Termination

Effective Date (Month / Day / Year)	Group No: _____ Group Name: _____	Social Security No. - -

SUBSCRIBER INFORMATION (Please print legibly):

LAST NAME:_____ FIRST:_____ MI____

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHONE NUMBER:(____)_____

Date of Birth ____/____/____ (MM DD YY)

Date of Hire ____/____/____ (MM DD YY)

Marital Status: ☐ Single ☐ Married

Sex: ☐ Male ☐ Female

DDPV USE ONLY:

( ) Add ( ) Reinstate
( ) Change ( ) Correct
( ) Transfer ( ) Delete

Current _____
Change _____
Date Rec'd _____
Date Proc _____
Billing Rep _____

PLAN & TYPE OF COVERAGE SELECTED

Product (check one)
☐ DeltaPreferred ☐ DeltaCare
☐ DeltaPremier ☐ DeltaVoluntary
☐ Delta Plan 70/80/100

Type (check one):
☐ Employee
☐ Employee/Spouse
☐ Employee/Child
☐ Employee/Children
☐ Employee/Family
☐ Other

*Please check the box(es) next to the reason(s) for your change:

☐ Add Dependent(s) **listed below**
☐ Remove Dependent(s) **listed below**
☐ Name Change - Previous Name_____
☐ Change Coverage
☐ Address Change Only

Reason(s) for Change:
☐ Marriage
☐ Divorce
☐ Birth or adoption of child
☐ Other _____
☐ Loss of spouse's coverage
☐ No longer dependent child
☐ Death of dependent

LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY A CHANGE

Last (if different) **First** **MI**	**Sex** M/F	**Birthdate** Month/Day/Year
1. SPOUSE		
2.		
3.		
4.		
5.		
6.		

PLEASE INDICATE DENTAL OFFICE CHOICE ONLY IF DELTACARE PRODUCT IS SELECTED

Provider Name_____ Provider Number_____ Provider Loc. #_____

OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Will you, your spouse, or any dependent children be covered under any other group dental plan while this policy is in effect? ☐ Yes ☐ No
If yes, complete the following: Are dependents covered? ☐ Yes ☐ No
Name of Carrier:_____ Group Number:_____
Street Address of Carrier:_____
City:_____ State:_____ Zip:_____
Name of Employer or Group this coverage is available from:_____

AUTHORIZATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental Plan of Virginia, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

CERTIFICATION

I understand that my selection of coverage may be changed only during the open enrollment period of each year unless I experience a qualifying event listed under "Reason for Change". I certify that the information supplied by me on this form is accurate to the best of my knowledge.

☐ I have been offered the opportunity to enroll in the dental program through Delta; however, I waive coverage at this time. I further understand that I will not be eligible to enroll until the next open enrollment period.

Signature:_____ Date:_____